TITLE 10: CALIFORNIA CODE OF REGULATIONS
CHAPTER 5.8 MANAGED RISK MEDICAL INSURANCE BOARD
HEALTHY FAMILIES PROGRAM

Article 4. Risk Categories and Family Contributions
Amend Section 2699.6805

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Text proposed to be deleted is displayed in ~~strikeout~~ type.

Section 2699.6805 is amended to read:

2699.6805. Designation of Community Provider Plan.

(a) For each benefit year, the Board will designate as the community provider plan in each county the participating health plan with a service area that includes zip codes in which at least eighty-five percent (85%) of the residents of the county reside and that has the highest percentage of traditional and safety net providers pursuant to the calculation in subsection (g) below.

(b) ~~By the first day of~~ In November of the benefit year immediately preceding the benefit year described in subsection (a), the Board shall compile and make available a list for each county of all Child Health and Disability Prevention Program (CHDP), clinic and hospital traditional and safety net providers.

(c) The lists shall be compiled as follows:

(1) The CHDP list shall include all CHDP providers, except for clinical laboratories, that were on the Department of Health Care Services (DHCS) CHDP Master File as of October 1st of the benefit year immediately preceding the benefit year described in subsection (a) and that provided a State-only funded CHDP service as identified on the CHDP Paid Claims Tape to at least one (1) child aged one (1) through eighteen (18) in the state fiscal year that ended immediately prior to the most recently ended state fiscal year. For each listed provider, the list shall indicate the percentage of county children that received State-only funded CHDP services from listed provider. The percentage shall be calculated by dividing the number of county children receiving State-only funded services from the listed provider by the total number of county children receiving State-only funded services from all listed providers in the county.

(2) The clinic list shall include all Community Outpatient Hospital Based Clinics, Rural Health Clinics, Federally Qualified Health Centers, Free

Clinics, Community Clinics, Clinics Exempt from Licensure, County Clinics Not With Hospital and County Hospital Outpatient Clinics, in the county, that were so identified by the Medi-Cal program as of October 1st of the benefit year immediately preceding the benefit year described in subsection (a) and were identified on the Medi-Cal Paid Claims Tape as having provided ~~at least (15) services to children~~ at least one (1) service to a child aged one (1) through eighteen (18) in the state fiscal year that ended immediately prior to the most recently ended state fiscal year. The list shall indicate a percentage for each clinic which shall be equal to one (1) divided by the number of listed clinics in the county.

(3) The hospital list shall be compiled as follows:

(A) For a county that has, located in the county, at least one hospital which, as of October 1st of the benefit year immediately preceding the benefit year described in subsection (a), was a hospital eligible for the inpatient disproportionate share hospital payment program as reported by DHCS, a University teaching hospital, a Children's Hospital (as defined in Section 10727 of the Welfare and Institutions Code), or a county owned and operated general acute care hospital, the list shall include all hospitals of one of these types whether or not they are located in the county and which reported to the Office of Statewide Health Planning and Development (OSHPD) discharging at least one resident of the county who was a Medi-Cal, county indigent, or charity care patient aged one (1) through eighteen (18) in the year for which OSHPD most recently released its annual compilation of Discharge Data. The list shall indicate, for each hospital, the percentage of the Medi-Cal, county indigent, and charity care discharges of county residents aged one (1) through eighteen (18) from the listed hospital. The hospital list shall not include acute psychiatric hospitals (as defined in Section 1250(b) of the Health and Safety Code), psychiatric health facilities (as defined in Section 1250.2(a) of the Health and Safety Code), or chemical dependency recovery hospitals (as defined in Section 1250.3(a) of the Health and Safety Code).

(B) For all other counties, the list shall include all hospitals located in the county and all hospitals located outside the county, which, as of October 1st of the benefit year immediately preceding the benefit year described in subsection (a), discharged at least one resident of the county who was a Medi-Cal, county indigent, or charity care patient aged one (1) through eighteen (18) in the year for which OSHPD most recently released its annual compilation of Discharge

Data and which were hospitals eligible for the inpatient disproportionate share hospital payment program as reported by DHCS, a university teaching hospital, a children's hospital (as defined in Section 10727 of the Welfare and Institutions Code), or a county owned and operated general acute care hospital. The list shall indicate, for each hospital, the percentage of the Medi-Cal, county indigent, and charity care discharges of county residents aged one (1) through eighteen (18) from the listed hospital. The hospital list shall not include acute psychiatric hospitals (as defined in Section 1250(b) of the Health and Safety Code), psychiatric health facilities (as defined in Section 1250.2(a) of the Health and Safety Code), or chemical dependency recovery hospitals (as defined in Section 1250.3(a) of the Health and Safety Code).

(d) The lists of CHDP providers, clinics and hospitals described in subsection (c) shall be revised only under the following circumstances:

(1) Any CHDP provider not included on a county list pursuant to subsection (c)(1) or any participating health plan that asserts the CHDP provider met the specified criteria to be on that list and was excluded in error may, within thirty (30) calendar days after the list described in subsection (b) is released by the Board, provide written documentation to the Board demonstrating that the CHDP provider met the criteria described in subsection (c)(1). If the Executive Director of the Board finds that the CHDP provider met the specified criteria then the CHDP provider shall be added to the county list.

(2) Any clinic not included on a county list pursuant to subsection (c)(2) or any participating health plan that asserts the clinic met the specified criteria to be on that list and was excluded in error may, within thirty (30) calendar days after the list described in subsection (b) is released by the Board, provide written documentation to the Board demonstrating that the clinic met the criteria as described in subsection (c)(2). If the Executive Director of the Board finds that the clinic met the specified criteria then the clinic shall be added to the county list.

(3) Any hospital not included on a county list pursuant to subsection (c)(3) or any participating health plan that asserts the hospital met the specified criteria to be on that list and was excluded in error may, within thirty (30) calendar days after the list described in subsection (b) is released by the Board, provide written documentation to the Board demonstrating that the hospital met the criteria described in subsection (c)(3). If the Executive Director of the Board finds that the hospital met the specified criteria then the hospital shall be added to the county list.

(e) The Board shall compile and make available a final list for each county of ~~Child Health and Disability Prevention (~~CHDP~~)~~, clinic, and hospital traditional and safety net providers after the ~~30-day~~ revision period described in subsection (d) has expired. For the benefit year described in section (a) that commences July 1, 2009 only, the final list shall be the list made available January 22, 2009.

(f) By January 15 of the benefit year immediately preceding the benefit year described in subsection (a), each participating health plan shall submit the following to the Board for each county:

(1) A list of the CHDP providers identified by the Board pursuant to subsection (e) that have a contractual relationship with the participating health plan for the provision of services to program subscribers.

(2) A list of the clinics identified by the Board pursuant to subsection (e) that have a contractual relationship with the participating health plan for the provision of services to program subscribers.

(3) A list of the hospitals identified by the Board pursuant to subsection (e) that have a contractual relationship with the participating health plan for the provision of services to program subscribers.

(4) For the benefit year described in section (a) that commences July 1, 2009 only, the lists described in subsections (f)(1), (2) and (3) shall be those lists submitted by the health plans prior to the effective date of this subsection.

(g) The percentage of traditional and safety net providers in the provider network of each participating health plan will be calculated by summing the CHDP percentage, the clinic percentage, and the hospital percentage.

(1) The CHDP percentage is calculated by summing the ~~number of CHDP services provided to all children aged one (1) through eighteen (18) by listed CHDP providers within the county that were identified by the plan pursuant to (f)(1), and dividing this sum by the number of services provided by all listed CHDP providers in the county~~ percentages assigned to the CHDP providers pursuant to Section (c)(1) that were identified by the plan pursuant to (f)(1), and multiplying that number by 0.35.

(2) The clinic percentage is calculated by~~:~~ summing the percentages assigned to each listed clinic in the county pursuant to subsection (c)(2) that was identified by the plan pursuant to subsection (f)(2) and multiplying that number by 0.45.

~~(A) Adding the percentages assigned to each listed clinic in the county pursuant to subsection (c)(2) that was identified by the plan pursuant to subsection (f)(2), and multiplying that percentage by 0.225; and adding the number produced by the calculation made in subsection (g)(2)(B) below.~~

~~(B) Dividing the number of services provided by each listed clinic in the county that was identified by the plan pursuant to subsection (f)(2) by the number of services provided by all listed clinics in the county pursuant to subsection (c)(2), and multiplying that percentage by 0.225.~~

(3) The hospital percentage is calculated by summing the percentages assigned to each hospital pursuant to ~~described in~~ subsection (c)(3) ~~assigned to all hospitals in the county~~ identified by the plan pursuant to ~~(d)~~(f)(3), and multiplying that number by 0.2.

(h) The Board shall designate a community provider plan for each county for the benefit year described in subsection (a). Notwithstanding subsection (h) of section 2600.6500, the designation shall take effect on the day the open enrollment transfers described in section 2699.6621 take effect, and the previous designation shall remain in effect until that time. Prior to designation, each plan's relationships with traditional and safety net providers may be verified by the Board.

NOTE: Authority cited: Section 12693.21, Insurance Code. Reference: Sections 12693.21 and 12693.37, Insurance Code.